GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION
MEDICINE & OSTEOPATHY

Section 3B. BUSINESS ADDRESS

A PO Box may not be used for an address. Please provide a street address. Please note: This information will be made available to the public.

GEORGETOWN UNIVERSITY HOSPITAL
COMPANY NAME

JUN 12 2007
BY:

☐ APARTMENT ☐ SUITE ☐ FLOOR NUMBER

DEPARTMENT OF NEUROLOGY, PHC BLDG
BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

3800 RESERVOIR ROAD, NW
BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

WASHINGTON
CITY

DC 20007 –
STATE ZIP CODE + 4

202 – 444 – 8525 – – –
BUSINESS PHONE NUMBER BUSINESS FAX NUMBER E-MAIL ADDRESS

Section 3C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license will be your business address.

☒ HOME ☐ BUSINESS

Section 4. PREVIOUS NAME CHANGE

If your name has changed at any point since you first registered with the American Medical Association, taken any exams or attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate
FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate (e.g. "Jr.", "Sr." not "M.D.")
FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate (e.g. "Jr.", "Sr." not "M.D.")
FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate (e.g. "Jr.", "Sr." not "M.D.")

SECTION 5. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Keep a photocopy of all supporting documents for your records.

A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	YES ☒ NO ☐	HPLA ONLY
B.	Three (3) characters reference forms.	YES ☒ NO ☐	☐
C.	AMA Profile.	YES ☒ NO ☐	☐
D.	Verification(s) of licensure -- These should be provided in a sealed envelope from the issuing jurisdiction for each license identified in Section 6C.	YES ☐ NO ☒	☐
E.	All undergraduate, graduate, medical, and profession school transcripts. These transcripts should be provided in a sealed envelope from the issuing institution for each of the schools that you attended and listed in Section 6A on the previous page.	YES ☒ NO ☐	☐

SECTION 5. SUPPORTING DOCUMENTS (continued)

F.	Documentation of all experience following graduation from medical school. Proof of experience should be submitted as a letter from the overseeing institution/organization.	YES ☒ NO ☐	☐
G.	Examination scores – These should be provided in a sealed envelope from the examination contractor or administrator.	YES ☒ NO ☐	☐
H.	ECFMG Certificate (if Foreign applicant).	YES ☒ NO ☐	☐
I.	FMGEMS Certificate (if Fifth Pathway applicant)	YES ☐ NO ☒	☐
J.	Eminence application package (If Eminence 1 or 2 applicant)	YES ☐ NO ☒	☐

Section 6A. POST SECONDARY SCHOOLS ATTENDED

List all colleges and universities attended prior to and including medical schools, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation	Type of Degree/Certificate
HUMBOLDT UNIVERSITY, BERLIN, GERMANY	05/04/98	M. D.

Section 6B. MEDICAL TRAINING AND MEDICAL PRACTICE – POSTGRADUATE EXPERIENCE

List ALL experience since medical school graduation below. Include letters (No Certificates) from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description", use the letter key below. List experience in reverse chronological order, beginning with the most recent. Be sure to account for periods of unemployment greater than three (3) months. Please account for all time since medical school graduation.

Organization/Institution	Start Date	End Date	Type of Position (Use Key Below)*
GEORGETOWN UNIVERSITY, WDWD	07/01/04	06/30/07	C
ST. FRANCIS MED. CENTER	07/01/02	06/30/04	B
BAYLOR COLLEGE OF MEDICINE	09/01/00	06/30/03	A (Research)
HUMBOLDT UNIVERSITY BERLIN, GERM.	03/01/99	08/31/00	B (Germany)

* TYPE OF POSITION KEY / TRAINING AND PRACTICE DESCRIPTIONS

A. Fellowship
B. Internship
C. Residency
D. Employment
E. Private Practice
F. Other (Attach a typed explanation on a separate sheet of paper to this form.)

Section 6C. MEDICAL LICENSES IN OTHER STATES/JURISDICTIONS

List ALL states and jurisdictions in which you have ever held a license (excluding training licenses). Provide letters of verification from original and current jurisdictions (if different).

Jurisdiction	Date License Was First Obtained	License Number

SECTION 7. SCREENING QUESTIONS – Applicants MUST answer all of the following questions.

Please answer questions A through K by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through K below, you must provide full information and complete details on a separate sheet of paper, including copies of all relevant court documents, and attach to this form.

A.	**Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.** Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001). IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED. As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: Yes ☐ No ☒ 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)? The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).	YES ☐ NO ☐	HPLA ONLY
B.	Have you ever been convicted or investigated of a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☒	☐
C.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☒	☐
D.	Have you ever voluntarily surrendered a license or privileges after formal charges have been filed against you or while under investigation?	YES ☐ NO ☒	☐
E.	Has any authority taken adverse action against your medicine/osteopathy license or privileges or informed you of any pending charges not previously reported to this Board?	YES ☐ NO ☒	☐
F.	Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	YES ☐ NO ☒	☐
G.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES ☐ NO ☒	☐
H.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐ NO ☒	☐
I.	Within the last ten (10) years, have you been treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	YES ☐ NO ☒	☐

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION
MEDICINE & OSTEOPATHY

RECEIVED JUN 12 2007

J.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES ☐ NO ☒	☐
K.	Have you ever been terminated due to practice issues or moral turpitude issues since obtaining you (professional) license within the last ten (10) years?	YES ☐ NO ☒	☐
L.	MD's Only – If your practice is limited to a specialty, please indicate the code from the specialty listed below. NEUROLOGY CODE	☒	☐
M.	MD's Only – If you are certified by the "American Board of" any specialty, please indicate the code from the specialty list below. CODE	☒	☐

SPECIALTIES

AD	Administrative Medicine	NE	Neurological Surgery	PH	Physical Medicine & Rehabilitation
AL	Allergy & Immunology	NU	Nuclear Medicine	PL	Plastic Surgery
AN	Anesthesiology	OB	Obstetrics & Gynecology	PR	Preventive Medicine/Public Health
CO	Colon & Rectal Surgery	OP	Ophthalmology	PS	Psychiatry & Neurology
DE	Dermatology	OR	Orthopedic Surgery	RA	Radiology
EM	Emergency Medicine	OT	Otolaryngology	SU	Surgery
FA	Family Practice	PA	Pathology	TH	Thoracic Surgery
IN	Internal Medicine	PE	Pediatrics	UR	Urology
MG	Medical Genetics				

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE	NAME (Please Print)	DATE	HPLA ONLY
[signature]	PFEIFFER	05/20/2007	☐

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

Attachment IIa

RECEIVED JUN 12 2007 BY: ______

BOARD OF MEDICINE

LICENSE APPLICATION FOR MEDICINE & OSTEOPATHY

...section of this application and submit the original application and all required supporting documents. If more space is ...tach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and ...tion pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at **1-888-204-6193**, ... EST.

...ICENSE

...cense for which you are applying. ☒ Medicine and Surgery (MD) ☐ Osteopathy and Surgery (DO)

SECTION 1B. BASIS OF APPLICATION

Check the box next to the basis by which you are applying. "Do not select "EXAMINATION" if you have already passed the USMLE Step III Examination

	TOTAL
☐ Examination	$221
☐ Re-examination	$ 65
☒ Waiver of Examination – USMLE	$546
☐ Waiver of Examination – NBME/NBOME/LMCC	$546
☐ Waiver of Examination – FLEX	$546
☐ Waiver of Examination – State Constructed Exam	$546
☐ Waiver of Examination – Combination of Above	$546
☐ Eminence 1	$546
☐ Eminence 2	$1950
☒ Duplicate Licenses (limit 5) 3 X $26.00 =	$ 78.00
Total Enclosed	$624.00

Make check or money order payable to Promissor, Inc.
A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

MAIL TO:
Department of Health
Health Professional Licensing Administration
Board of Medicine
717 – 14th St NW
Suite 600
Washington, DC 20005

HPLA ONLY		
Check $	Check #	Staff
$ 624.00	304	

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change document for EACH time that it has changed. Acceptable documents are marriage certificates, divorce decrees or court orders. Complete Section 4 below of this application on page 2.

MICHAEL M PFEIFFER

FIRST NAME / MI / LAST NAME / SUFFIX (e.g. "Jr." "Sr." not "M.D.")

SOCIAL SECURITY NUMBER*
If applicant does not provide a social security number, a sworn affidavit is required.

MM-DD-YYYY: 02 – 18 – 1963
DATE OF BIRTH

GERMANY
PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

☒ Male ☐ Female
GENDER
Please check the correct box.

Section 3A. HOME ADDRESS

A PO Box may not be used for an address. Please provide a street address.

☐ APARTMENT ☐ SUITE ☐ FLOOR NUMBER

8113 KILLY STONE DRIVE
HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

BETHESDA
CITY

MD 29817 –
STATE / ZIP CODE + 4

202 – 747 – 9270
HOME PHONE NUMBER

HOME FAX NUMBER

Michael M Pfeiffer
E-MAIL ADDRESS

* Under the authority of Public Law 93-579, Section 7 (b), the Department of Health requests your Social Security Number to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.

Approved by: Antoinette Stokes

MEDICAL BOARD

Attachment IIc

Application Date: 6/12/07

Social Security Number:

Date Package Complete:

Applicant's Name: Pfeiffer, Michael

License Type: MD

BTRS Batch Number: MDLI061207A6

Basis of Application: USMLE

Date Package Forwarded to DC:

	Acceptable Doc.*	3221 Exam (USMLE)	365 Re-Exam (USMLE)	3546 Flex Waiver	3546 NBME Waiver	3546 State Waiver	3546 Combo Waiver	3546 LMCC	3546 USMLE Waiver	3546 Em 1**	3546 Em 2**	Doc. Required	Documents Present								Date Rec'd	Proc. Assoc. Initials
SS# OR Sworn Affidavit	X	X	X	X	X	X	X	X	✓	X	X											
License Application (notarized)	O or C	X	X	X	X	X	X	X	✓	X	X											
Two Passport Type Photos	O	X	X	X	X	X	X	X	✓	X	X											
Clean Hands	O or C	X	X	X	X	X	X	X	✓	X	X											
Name Change- If Applicable***	O or C	X	X	X	X	X	X	X	N/A	X	X											
Three Character Reference Forms	O	X	O	X	X	X	X	X	✓	X	X											
AMA Profile	O	X	O	X	X	X	X	X	✓	X	X											
Verification of Licensure (if licensed in other jurisdictions)	O	X	O	X	X	X	X	X	N/A	X	X											
Undergraduate and Graduate School Transcripts	O	X	O	X	X	X	X	X	N/A	X	X											
Medical & Professional School Transcripts	O	X	O	X	X	X	X	X	X	X	X											
Documentation of all Post-Grad Experience (work/training experience)	O or N/C and/or H	X	O	X	X	X	X	X	X	X	X											
Examination Scores	O	USMLE 183	O	X	X	X	X	O	✓	X	O											
USMLE Exam registration form with 2 additional photos	O	X	X	O	O	O	O	O	X	X	O											
If Foreign Trained Physician	O	ECFMG Cert	O	ECFMG Cert	ECFMG Cert	ECFMG Cert	ECFMG Cert	O	ECFMG Cert	ECFMG Cert	ECFMG Cert											
Foreign Trained Physicians add: ECFMG Certificate	O or N/C	X	O	X	X	X	X	O	✓	X	X											
Fifth Pathway Applicants add: Fifth Pathway Program Certificate	O	X	X	X	X	X	X	X	X	O	O											
FMGEMS Certificate	O	X	O	X	X	X	X	X	X	O	O											
Eminence Applicants only add: Curriculum Vitae	C	O	O	O	O	O	O	O	O	X	X											
List of Publications	C	O	O	O	O	O	O	O	O	X	X											
List of Honors and Awards	C	O	O	O	O	O	O	O	O	X	X											
Letter of Recommendation from Institution Head	O	O	O	O	O	O	O	O	O	O	X											
H1 Visa Status Certificate	O	O	O	O	O	O	O	O	O	O	X											
5 Letters from Renowned American Specialist in Field	O	O	O	O	O	O	O	O	O	O	X											
Letter of Acceptance from Sponsoring Institution	O	O	O	O	O	O	O	O	O	O	X											

ALL APPLICANTS WHO ANSWER "YES" TO A SCREENING QUESTION MUST SUBMIT AN EXPLANATION FOR EACH "YES" RESPONSE

SCREENING QUESTIONS	ANSWER	Support Doc	Date Rec'd	Initials
QUESTION 7A	N			
QUESTION 7B				
QUESTION 7C				
QUESTION 7D				
QUESTION 7E				
QUESTION 7F				
QUESTION 7G				
QUESTION 7H				
QUESTION 7I				
QUESTION 7J				

* Refer to Key. X= Required O= Not Required

** Eminence applicants must also submit packages with information concerning their careers. This information will be evaluated for completeness by the DC Medical Board.

*** All applicants requesting a name change must provide a marriage license, divorce decree, or court order (Copies are acceptable.)

Key	
C	Copy
DC	Forward to the client
H	Hardship
N/C	Notarized copy
P	Photo
R	USMLE

Return Letter Info.	
Date	Letter #
/ /	
/ /	
/ /	
/ /	
/ /	

NOTE: Remember to move items in Checklist box to Completed Items box upon receipt of EACH supporting document. Enter REMARKS for specific items if there are outstanding issues.
Note: If applicant does not provide a social security number, they must provide a sworn affidavit stating that they do not have a social security number.